Missouri Department of
SOCIAL SERVICES
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MoHealth Net

PROVIDER BULLETIN

CMS-1500 (08-05) HEALTH INSURANCE CLAIM FORM

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CLARIFICATION OF THE CMS-1500 (08-05) HEALTH INSURANCE CLAIM FORM BILLING INSTRUCTIONS

MO HealthNet Division (MHD) is making revisions to the CMS-1500 (08-05) Health Insurance Claim Form billing instructions to clarify information on the National Provider Identifier (NPI) and Provider Taxonomy Codes. Please refer to the following National Provider Identifier Bulletins for more information regarding NPI requirements: Volume 30, Number 47, dated February 29, 2008; and Volume 30, Number 57, dated May 5, 2008.

CMS-1500 (08-05) billing instructions have been revised for Field Number 17a, 24i, 24j, 32b and 33b:

Field Number & Name	Requirements	Instructions for Completion
1. Type of Health Insurance Coverage	Optional	Show the type of health insurance coverage applicable to this claim by checking the appropriate box. For example, if a Medicare claim is being filed check the Medicare box, if a MO HealthNet claim is being filed check the MO HealthNet box and if the patient has both Medicare and MO HealthNet, check both boxes.
1a. Insured's I.D. Number	Required	Enter the patient's eight-digit MO HealthNet ID number (DCN) as shown on the patient's ID card.
2. Patient's Name	Required	Enter last name, first name, middle initial in that order as it appears on the ID card.

Field Number & Name	Requirements	Instructions for Completion
3. Patient's Birth Date, Sex	Optional	Enter month, day, and year of birth, mark appropriate box.
4. Insured's Name	Required when applicable	If there is individual or group insurance besides MO HealthNet, enter the name of the primary policyholder. If this field is completed, also complete Fields #6, #7, #11, and #13. If no private insurance is involved, leave blank.
5. Patient's Address	Optional	Enter address and telephone number if available.
6. Patient's Relationship to Insured	Required when applicable	Mark appropriate box if there is other insurance.
7. Insured's Address	Required when applicable	Enter the primary policyholder's address; enter policyholder's telephone number, if available. If no private insurance is involved, leave blank.
8. Patient Status	Optional	Not Used.
9. Other Insured's Name	Required when applicable	If there is other insurance coverage in addition to the primary policy, enter the secondary policyholder's name. NOTE: This field is for private insurance information only. If no private insurance is involved LEAVE BLANK. If Medicare, MO HealthNet, employer's name or other information appears in this field, the claim will deny.
9a. Other Insured's Policy or Group Number	Required when applicable	Enter the secondary policyholder's insurance policy number or group number, if the insurance is through a group such as an employer, union, etc. NOTE: This field is for private insurance information only. If no private insurance is involved LEAVE BLANK. If Medicare, MO HealthNet, employer's name or other information appears in this field, the claim will deny.
9b. Other Insured's Date of Birth	Required when applicable	Enter the secondary policyholder's date of birth and mark the appropriate box for sex. NOTE: This field is for private insurance information only. If no private insurance is involved LEAVE BLANK. If Medicare, MO HealthNet, employers name or other information appears in this field, the claim will deny.
9c. Employer's Name	Required when applicable	Enter the secondary policyholder's employer name. NOTE: This field is for private insurance information only. If no private insurance is involved LEAVE BLANK. If Medicare, MO HealthNet, employer's name or other information appears in this field, the claim will deny.
9d. Insurance Plan Name or Program Name	Required when applicable	Enter the other insured's insurance plan or program name. If the insurance plan denied payment for the service provided, attach a valid denial from the insurance plan. NOTE: This field is for private insurance information only. If no private insurance is involved LEAVE BLANK. If Medicare, MO HealthNet, employer's name or other information appears in this field, the claim will deny.

Field Number & Name	Requirements	Instructions for Completion
10a.-10c. Is Condition Related to:	Required when applicable	If services on the claim are related to patient's employment, auto accident or other accident, mark the appropriate box. If the services are not related to an accident, leave blank.
10d. Reserved for Local Use	Optional	May be used for comments/descriptions.
11. Insured's Policy or Group Number	Required when applicable	Enter the primary policyholder's insurance policy number or group number, if the insurance is through a group, such as an employer, union, etc. NOTE: This field is for private insurance information only. If no private insurance is involved LEAVE BLANK. If Medicare, MO HealthNet, employer's name or other information appears in this field, the claim will deny.
11a. Insured's Date of Birth, Sex	Required when applicable	Enter primary policyholder's date of birth and mark the appropriate box reflecting the sex of the primary policyholder. NOTE: This field is for private insurance information only. If no private insurance is involved LEAVE BLANK. If Medicare, MO HealthNet, employer's name or other information appears in this field, the claim will deny.
11b. Employer's Name	Required when applicable	Enter the primary policyholder's employer name. NOTE: This field is for private insurance information only. If no private insurance is involved LEAVE BLANK. If Medicare, MO HealthNet, employer's name or other information appears in this field, the claim will deny.
11c. Insurance Plan Name	Required when applicable	Enter the primary policyholder's insurance plan name. If the insurance plan denied payment for the service provided, attach a valid denial from the insurance plan. NOTE: This field is for private insurance information only. If no private insurance is involved LEAVE BLANK. If Medicare, MO HealthNet, employer's name or other information appears in this field, the claim will deny.
11d. Other Health Plan	Required when applicable	Indicate whether the patient has a secondary health insurance plan; if so, complete Fields 9 - 9d with the secondary insurance information. NOTE: This field is for private insurance information only. If no private insurance is involved LEAVE BLANK. If Medicare, MO HealthNet, employer's name or other information appears in this field, the claim will deny.
12. Patient's Signature	Not Used	Leave blank.

Field Number & Name	Requirements	Instructions for Completion
13. Insured's Signature	Required when applicable	This field should be completed only when the patient has another health insurance policy. Obtain the policyholder's or authorized person's signature for assignment of benefits. The signature is necessary to ensure the insurance plan pays any benefits directly to the provider of MO HealthNet. Payment may otherwise be issued to the policyholder requiring the provider to collect insurance benefits from the policyholder.
14. Date of Current Illness, Injury or Pregnancy	Required when applicable Not required for: Ambulance, Comprehensive Day Rehab, Environmental Lead, Hearing Aid, Optical, Rehabilitation Centers or Therapy.	This field is required when billing global prenatal, global OB, and delivery services. The date should reflect the last menstrual period (LMP).
15. Date Same/Similar Illness	Not Used	Leave blank.
16. Dates Patient Unable to Work	Not Used	Leave blank.
17. Name of Referring Provider or Other Source	Required when applicable Required for independent laboratory and radiology providers and physicians with a specialty of 30 for radiology/radiation therapy. Not required for: Ambulance, DME, Optical or Rehabilitation Centers	Enter the name of the referring provider or other source. If multiple providers are involved, enter one provider using the following priority order: 1. Referring Provider 2. Ordering Provider 3. Supervising Provider

Field Number & Name	Requirements	Instructions for Completion
17a. Other ID #	Required when applicable Required for independent laboratory and radiology providers and physicians with a specialty of 30 for radiology/radiation therapy. Not required for: Ambulance, DME, Optical or Rehabilitation Centers	Enter the Provider Taxonomy qualifier ZZ in the first shaded area if the provider reported in Field 17b is required to report a Provider Taxonomy Code to MO HealthNet. Enter the corresponding 10-digit Provider Taxonomy Code in the second shaded area for the provider reported in Field 17b.
17b. NPI	Required when applicable Not required for: Ambulance, DME, Optical or Rehabilitation Centers	Enter the NPI number of the referring, ordering, or supervising provider.
18. Hospitalization Dates	Required when applicable Not required for: Ambulance, Comprehensive Day Rehab, Environmental Lead, Hearing Aid, Optical, Rehabilitation Centers or Therapy	If the services on the claim were provided in an inpatient hospital setting, enter the admit date. This field is required when the service is performed on an inpatient basis.
19. Reserved for Local Use	Optional	Providers may use this field for additional remarks/descriptions. **Optical:** If the claims are for frames and/or lens(es), the prescription of the lens(es) must be written in this space. When applicable, the cylinder must be written in minus. **Rehabilitation Centers and Therapy:** Enter the amount of time spent by the therapist in fabricating/applying cast/splint.

Field Number & Name	Requirements	Instructions for Completion
20. Lab Work Performed Outside Office	Required when applicable Not required for: Ambulance, Comprehensive Day Rehab, Environmental Lead, Hearing Aid, Optical, Rehabilitation Centers or Therapy.	If billing for laboratory charges, mark appropriate box. The referring physician may not bill for lab work that was referred out.
21. Diagnosis	Required	Enter the complete ICD-9-CM diagnosis code(s). Enter the primary diagnosis as No. 1, the secondary diagnosis as No. 2, etc.
22. MO HealthNet Resubmission	Required when applicable	For timely filing purposes, if this is a resubmitted claim, enter the Internal Control Number (ICN) of the previous related claim or attach a copy of the original Remittance Advice indicating the claim was initially submitted timely.
23. Prior Authorization Number	Not Used	Leave blank.
24a. Date of Service	Required	Enter the date of service under "from" in month/day/year format, using six-digit format in the unshaded area of the field. All line items must have a from date. A "to" date of service is required when billing on a single line for subsequent physician hospital visits on consecutive days. The six service lines have been divided to accommodate submission of both the NPI and another/proprietary identifier during the NPI transition and to accommodate the submission of supplemental information to support the billed service. The top area of the service lines are shaded and is the location for reporting supplemental information. It is not intended to allow the billing of 12 lines of service. **Hearing Aid and Optical:** A "to" date of services is not used. The date of service for frames, lenses, and hearing aids and related services must be the date the items were dispensed. **Therapy and Rehabilitation Centers:** A "to" date of service is not required. **DME:** A "from" and "to" date is required when billing for DME rental.

Field Number & Name	Requirements	Instructions for Completion
24b. Place of Service	Required	Enter the appropriate place of service code in the unshaded area of the field: **Ambulance:** Place of service is the destination of the ambulance trip.
24c. EMG-Emergency	Required when applicable Not required for: Comprehensive Day Rehab, Environmental Lead, Hearing Aid, Optical, Rehabilitation Centers or Therapy.	Enter a Y in the unshaded area of the field if this is an emergency. If this is not an emergency, leave this field blank.
24d. Procedure Code	Required	Enter the appropriate CPT or HCPCS code and applicable modifier(s), if any, corresponding to the service rendered in the unshaded area of the field. (Field #19 may be used for remarks or descriptions.)
24e. Diagnosis Pointer	Required	Enter 1, 2, 3, 4 or the actual diagnosis code(s) from Field #21in the unshaded area of the field.
24f. Charges	Required	Enter the provider's usual and customary charge for each line item in the unshaded area of the field. This should be the total charge if multiple days or units are shown. **Optical and Hearing Aid:** Do not subtract the copay or cost sharing amount from the charge.
24g. Days or Units	Required	Enter the number of days or units of service provided for each detail line in the unshaded area of the field. The system automatically plugs a "1" if the field is left blank. **Ambulance:** Units shown must reflect the total "loaded" mileage one-way from point of pick-up to destination. **Anesthesia:** Enter the total number of minutes of anesthesia. **Consecutive visits**—Subsequent hospital visits may be billed on one line if they occur on consecutive days. The days/units must reflect the total number of days shown in Field #24a. **DME:** DME rental equipment under the regular DME program, the "from" and "to" dates of service should reflect the month, or portion of the month, in which the item is rented. The quantity must always be a "1". When billing ostomy supplies under procedure code A4421, the quantity is always a "1".

Field Number & Name	Requirements	Instructions for Completion
24h. EPSDT/Family Planning	Required when applicable	If the service is an EPSDT/HCY screening service or referral, enter "E". If the service is family planning related, enter "F". If the service is both an EPSDT/HCY and Family Planning enter "B".
24i. ID Qualifier	Required when applicable	Enter the Provider Taxonomy qualifier ZZ in the shaded area if the rendering provider is required to report a Provider Taxonomy Code to MO HealthNet. A provider taxonomy code must be reported if providers have one NPI for multiple legacy MO HealthNet provider numbers.
24j. Rendering Provider ID	Required when applicable Not Required for: Ambulance	If the Provider Taxonomy qualifier was reported in 24I; enter the 10 digit Provider Taxonomy Code in the shaded area. Enter the 10-digit NPI number of the individual rendering the service in the unshaded area.
24k. Removed		
25. SS#/Fed. Tax ID	Not Used	Leave blank.
26. Patient Account Number	Optional	For the provider's own information, a maximum of 12 alpha and/or numeric characters may be entered here.
27. Assignment	Not Used	Not required on MO HealthNet claims.
28. Total Charge	Required	Enter the sum of the line item charges.
29. Amount Paid	Optional	Enter the total amount received by all other insurance resources. Previous MO HealthNet payments, Medicare payments, cost sharing and copay amounts are not to be entered in this field.
30. Balance Due	Optional	Enter the difference between the total charge (Field #28) and the insurance amount paid (Field #29).

Field Number & Name	Requirements	Instructions for Completion
31. Provider Signature	Not Used	Leave Blank
32. Name and Address of Facility	Required when applicable	If services were rendered in a facility other than the home or office, enter the name and location of the facility. This field is required when the place of service is other than home or office.
32a. NPI #	Required when applicable	Enter the 10-digit NPI number of the service facility location in 32.
32b. Other ID#	Required when applicable	Enter the Provider Taxonomy qualifier ZZ and corresponding 10-digit Provider Taxonomy code for the NPI number reported in Field 32a if the provider is required to report a Provider Taxonomy Code to MO HealthNet. Do not enter a space, hyphen or other separator between the qualifier and code. A provider taxonomy code must be reported if providers have one NPI for multiple legacy MO HealthNet provider numbers.
33. Provider Name/ Number/Address	Required	Affix the billing provider label or write or type the information exactly as it appears on the label.
33a. NPI #	Required when applicable	Enter the NPI number of the billing provider in 33.
33b. Other ID #	Required when applicable	Enter the Provider Taxonomy qualifier ZZ and corresponding 10-digit Provider Taxonomy code for the NPI number reported in Field 33a if the provider is required to report a Provider Taxonomy Code to MO HealthNet. Do not enter a space, hyphen or other separator between the qualifier and code.

TRANSPLANT DONOR CMS-1500 INSTRUCTIONS

For transplant donor claims, please refer to Section 15.5 of the Transplant Manual for more instructions, click on the following link to review this manual:
http://manuals.momed.com/manuals/.

Provider Bulletins are available on the MO HealthNet Division (MHD) (Formerly the Division of Medical Services) Web site at http://dss.mo.gov/mhd/providers/pages/bulletins.htm. Bulletins will remain on the Provider Bulletins page only until incorporated into the provider manuals as appropriate, then moved to the Archived Bulletin page.

MO HealthNet News: Providers and other interested parties are urged to go to the MHD Web site at http://dss.missouri.gov/mhd/global/pages/mednewssubscribe.htm to subscribe to the electronic mailing list to receive automatic notifications of provider bulletins, provider manual updates, and other official MO HealthNet communications via E-mail.

MO HealthNet Managed Care: The information contained in this bulletin applies to coverage for:

- MO HealthNet Fee-for-Service
- Services not included in MO HealthNet Managed Care

Questions regarding MO HealthNet Managed Care benefits should be directed to the patient's MO HealthNet Managed Care health plan. Before delivering a service, please check the patient's eligibility status by swiping the red MO HealthNet card or by calling the Interactive Voice Response (IVR) System at 573-635-8908 and using Option One for the red or white card.

Provider Communications Hotline
573-751-2896